STATE OF WASHINGTON

DEPARTMENT OF LICENSING

Click Here to Start, Then Tab From Field to Field

TO: **Examining Physician**

FROM: **Department of Licensing**
Professional Athletics
PO Box 9026
Olympia, WA 98507-9026
(360) 664-6644 or FAX (360) 570-4956

RE: **COVER LETTER AND CERTIFICATION OF PHYSICAL FOR BOXERS, BOXING REFEREES, MARTIAL ARTS PARTICIPANTS, AND WRESTLING PARTICIPANTS**

Return this completed page to the Department of Licensing at the above address.

APPLICANT NAME (*PLEASE PRINT*)		FEDERAL I.D. NUMBER *(BOXERS ONLY)*		
ADDRESS		CITY	STATE	ZIP
BIRTHDATE	SOCIAL SECURITY NO. *(REQUIRED PER RCW 26.23.150)*		TELEPHONE NO. ( )	
HEIGHT	WEIGHT	RING NAME		

I hereby certify that the physical examination, eye examination and the required lab and blood tests have been completed on the above named applicant and I find his/her medical conditon to be:

☐ Satisfactory; or ☐ Unsatisfactory

Recommendation:

☐ Grant license

☐ Deny license

NAME OF EXAMINING PHYSICIAN *(PRINT)*		TELEPHONE ( )	
PHYSICIAN'S SIGNATURE X		DATE	
ADDRESS	CITY	STATE	ZIP

The Department of Licensing has a policy of providing equal access to its services. If you need special accommodation, please call (360) 664-6644 or TTY (360) 664-8885.

Memo to Physician

All applicants should be in excellent health at the time of this physical in order to be recommended for licensure.

All required blood and urinalysis test results must be completed before recommending a person for a license.

If any applicant exceeds the minimum standard limits listed on page 3 of this form, or has any disease or condition that would be detrimental to their own health and safety or the health and safety of other participants or the general public, then you, as the examining physician, should indicate that you find this applicant in an unsatisfactory medical condition and recommend that this applicant's license be denied.

Blood tests are mandatory for communicable diseases or conditions; HIV/HEP B/HEP C. If any test is positive, mark unsatisfactory medical condition and recommend to deny license. **Please return only page one and two** to the Department of Licensing.

If you have any questions, please feel free to contact the Department of Licensing, Professional Athletics Section at (360) 664-6644.

STATE OF WASHINGTON
Department of
LICENSING

BUSINESS AND PROFESSIONS DIVISION
PROFESSIONAL ATHLETICS
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PHYSICAL EXAMINATION REPORT FOR BOXERS, BOXING REFEREES, MARTIAL ARTS PARTICIPANTS, AND WRESTLING PARTICIPANTS

Name _____

Ring Name _____

Home Address _____

City _____ State _____ Zip _____

Telephone No. ( ) _____ Birthdate _____

HISTORY: *(Past and Present)*
Answer all questions below:

1. Bleeding disorder ☐ Yes ☐ No
2. Seizures or convulsions ☐ Yes ☐ No
3. Rheumatic Fever ☐ Yes ☐ No
4. Asthma or shortness of breath ☐ Yes ☐ No
5. High Blood Pressure ☐ Yes ☐ No
6. Heart Disease ☐ Yes ☐ No
7. Tuberculosis ☐ Yes ☐ No
8. Sickle Cell Disease ☐ Yes ☐ No
9. A kidney, lung, testicle, or eye removed ☐ Yes ☐ No
10. Kidney disease ☐ Yes ☐ No
11. Concussion or unconsciousness ☐ Yes ☐ No
12. Mononucleosis ☐ Yes ☐ No
13. Medical allergies ☐ Yes ☐ No
14. Blurring of vision ☐ Yes ☐ No
15. Wear/Worn glasses or contact lenses ☐ Yes ☐ No
16. Hepatitis ☐ Yes ☐ No
17. Diabetes ☐ Yes ☐ No
18. Physical Impairment ☐ Yes ☐ No
19. Skin Disease ☐ Yes ☐ No
20. Chronic Cough ☐ Yes ☐ No
21. Frequent Headaches ☐ Yes ☐ No
22. Swollen joint, joint injury or dislocation ☐ Yes ☐ No
23. Spitting of blood ☐ Yes ☐ No
24. Surgery or hospitalization ☐ Yes ☐ No
25. Substance abuse ☐ Yes ☐ No
26. Communicable Diseases ☐ Yes ☐ No
27. Recent Fractures ☐ Yes ☐ No
28. Rupture (hernia) ☐ Yes ☐ No
29. Dizzy or Fainting Spells ☐ Yes ☐ No
30. Rheumatism/Arthritis ☐ Yes ☐ No

No one should present himself/herself for a physical or apply for a license who has any physical impairment which limits his/her ability, or any dangerous communicable diseases or any disease of the vital organs, whether acute or chronic.

Do you have any other information concerning your health, past or present, which is not covered by the above questions? ☐ Yes ☐ No If "yes", describe fully _____

_____

Are you taking any medication or drugs? ☐ Yes ☐ No If "yes", Name, address, phone number of prescribing physician, name of medication _____

_____

_____

How many knockouts have you suffered? _____ Date of last KO _____

Longest duration of unconsciousness _____

Length of time before resuming boxing after last KO _____

Have you ever been knocked unconscious in any other sport or activity? ☐ Yes ☐ No

WHEN ALL PAGES OF THIS FORM ARE COMPLETED, FORWARD PAGE ONE AND TWO ONLY.

Applicant Name _____

Vision Requirements

The Department of Licensing shall deny, suspend or revoke a license if it determines that the applicant or licensee cannot safely engage in activities because of a visual condition, including but not limited to one of the following:

1. Uncorrected visual acuity of less than 20/100 in either eye.
2. Corrected visual acuity of less than 20/60 in either eye (amblyopia), regardless of its cause.
3. A cataract in either eye which reduces vision to 20/40 or less.
4. Presence or history of retinal detachment or retinal tear (excluding choroidal tear), whether or not such condition has been treated.
5. Presence of primary glaucoma, whether or not such condition has been treated.
6. Presence of aphakia, pseudophskia or dislocated lens in either eye.

Applicants with the following conditions may be licensed if he/she presents satisfactory written evidence from an ophthalmologist stating that the person can safely engage in activities. The written evidence shall specifically address the problem, the effect if any, that participation may have on the problem, and the frequency of subsequent examinations.

a. Cataract in either eye and corrected vision is better than 20/40 or less.

b. Ocular pathology of any kind which is self-limiting or treatable and which generally results in a return to normal ocular function.

c. Any other visual condition which the Department determines would prevent the applicant or licensee from safely engaging in activities.

EYE EXAM	RIGHT	LEFT
Distant Vision	20/	20/
Near Vision	20/	20/
PUPILS (SIZE & SHAPE)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
ACCOMMODATION & LIGHT REFLEX	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
FUNDI (describe if abnormal)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
CATARACTS (describe)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
LIDS	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
GLAUCOMA	☐ No ☐ Yes	☐ No ☐ Yes

Applicant Name _____

MINIMUM STANDARDS — (All areas listed on physical exam must be within normal limits)

1. Blood pressure no higher than 160/90.
2. Temperature below 100.
3. No abnormal conditions that would limit participation ability.
4. No hernias containing abdominal contents on coughing or straining.
5. Normal reflexes.
6. No suppurative lesions on skin.
7. No indication of active renal disease.
8. Negative controlled substance and blood tests.
9. No electroencephalographic change.
10. No history of cerebral hemorrhage or any other serious head injury.
11. No communicable diseases present or other conditions that can be transmitted by blood or detrimental to applicant or others.

HEIGHT_____ **WEIGHT**_____ **TEMPERATURE**_____ **PULSE**_____

BLOOD PRESSURE_____

EARS: ..... ☐ Normal ☐ Abnormal Perforated drums: ..... ☐ Yes ☐ No

MOUTH AND PHARYNX: ..... ☐ Normal ☐ Abnormal

TEETH: ..... ☐ Normal ☐ Abnormal

LUNGS: ..... ☐ Normal ☐ Abnormal

HEART: Pulse Rhythm: ..... ☐ Regular ☐ Irregular
Apical Pulse: ..... ☐ Heaving ☐ Normal
Enlargement: ..... ☐ Yes ☐ No Murmurs: ..... ☐ Yes ☐ No

ABDOMEN: Enlargement of Liver: ... ☐ Yes ☐ No
Enlargement of Spleen: ..... ☐ Yes ☐ No
Hernia: ..... ☐ Femoral ☐ Inguinal ☐ Ventral

ENLARGED GLANDS: ..... ☐ Yes ☐ No **GOITER: .....** ☐ Yes ☐ No

GENITALIA: ..... ☐ Normal ☐ Abnormal
Discharge: ..... ☐ Yes ☐ No
Varicocele: ..... ☐ Yes ☐ No

REFLEXES:	Normal	Abnormal
Knee Jerk	☐ Rt ☐ Lft	☐ Rt ☐ Lft
Babinski	☐ Rt ☐ Lft	☐ Rt ☐ Lft
Romberg	☐	☐
Finger to Nose	☐	☐
Pupils	☐ Rt ☐ Lft	☐ Rt ☐ Lft

UPPER EXTREMITIES:	Normal	Abnormal
Hands	☐	☐
Wrists	☐	☐
Elbows	☐	☐
Shoulder Girdle	☐	☐
Lower Extremities	☐	☐

(Check for recent injury, fracture or swellings.)

Applicant Name _____

SKIN: Open or suppurative lesions: ... ☐ Yes ☐ No
Rash: ..... ☐ Yes ☐ No Boils: ..... ☐ Yes ☐ No

URINALYSIS: **Total Protein:** **Sugar:**

BLOOD:
Test for the following communicable diseases trasmitted by blood; HIV/HEP B/HEP C
(see Memo to Physician on page 2 of this form).

☐ Positive ☐ Negative

CONTROLLED SUBSTANCE: (If indicated or requested)

Results: _____

CHEST X-RAY: (If indicated or requested)

Results: _____

EKG: (If indicated or requested)

Results: _____

EEG: (If indicated or requested)

Results: _____

CT: (If indicated or requested)

Results: _____

MRI: (If indicated or requested)

Results: _____

Physician's remarks: _____

_____

_____

_____

_____

I have examined the above named subject and find him/her in a:

☐ Satisfactory ☐ Unsatisfactory

medical condition, therefore my recommendation for license is:

☐ Grant License ☐ Deny License

EXAMINING PHYSICIAN:

_____ X _____
PHYSICIAN'S NAME *(PLEASE PRINT)* PHYSICIAN'S SIGNATURE

_____ ( )
ADDRESS TELEPHONE NO.

_____ _____
CITY STATE ZIP DATE